TWIN CITIES SPINE CENTER

Please complete this intake questionnaire and bring with you to your appointment.

What is the reason for seeking spine care today? _____

How long have you had this problem? _____

How did your symptoms start: □ Suddenly □ Gradually □ Chronic/recurrent

Did any of the following contribute to your current spine problem?

□ Spine deformity
□ Fall/trauma
□ Work injury
□ Motor vehicle accident
□ House/yard work
□ Sports/leisure
□ Stress
□ Other_____

Have you had spine surgery in the past? □ No □ Yes **If Yes, Type of Procedure**_____

Date: _____ **Hospital:** _____

What activities/ positions make it worse:

□ Sitting
□ Standing
□ Walking
□ Lying down
□ Bending
□ Lifting
□ Coughing/sneezing
□ Sleep postures
□ Getting in/out of bed
□ Getting in/out of chair
□ Driving
□ Computer work
□ Stair climbing
□ Neck movements
□ Arm movements
□ Leg movements
□ First morning symptoms
□ End of day symptoms
□ Other: _____

What activities/positions/ interventions make it better:

□ Lying down
□ Sitting
□ Walking
□ Bending forward
□ Exercises
□ Changing positions
□ Reclined positions
□ Ice
□ Heat
□ Medications
□ Better as the day progresses
□ Other: _____

What treatment have you tried?

□ Physical therapy
□ Chiropractic
□ Injections
□ Anti-inflammatory medication
□ Narcotics
□ Bracing/back support
□ Pain clinic
□ Med Ex program
□ Surgery
□ Acupuncture
□ Other: _____

Of these treatments, what has been helpful? _____

Due to your spine problem, do you currently receive, or are you applying for compensation from any of the following?

□ Supplemental security income (SSI)
□ Social Security Disability Insurance (SSDI)
□ Worker's Compensation
□ Private Disability

Have you retained an attorney because of your current spine problem?

□ No □ Yes ***If yes***, **(circle one)**: Unknown Pending lawsuit Settled Lawsuit

Imaging Studies you've completed in the past 1-2 years: □ X-ray □ MRI □ CT □ Myelogram □ EMG □ Discogram

Name & Location of Imaging Studies: _____

Medical History: (check all that apply)

□ Anesthesia problem
□ ADD/ADHD
□ Alcoholism
□ Anemia
□ Anxiety
□ Arthritis(rheumatoid)
□ Arthritis(osteo)
□ Asthma
□ Atrial Fibrillation
□ Benign Prostatic Hypertrophy
□ Bleeding disorder
□ Bipolar disorder
□ Chronic Pain
□ COPD
□ Coronary Artery disease
□ Cancer Type_____
□ Deep Vein Thrombosis
□ Depression
□ Diabetes
□ GERD
□ HIV/AIDS
□ Hypercholesterolemia
□ Hypertension
□ Fibromyalgia
□ Liver disease
□ Migraine headaches
□ Myocardial infarction
□ Osteoporosis/osteopenia
□ Parkinson's
□ Pulmonary Embolism
□ Kidney disease
□ Seizure disorder
□ Sleep Apnea
□ Stomach/Duodenal ulcer
□ Stroke(CVA)
□ Substance Abuse
□ Thyroid disease
□ Tuberculosis
□ Other:_____
□ Other:_____
□ Other:_____
□ Other:_____

Surgical History: (check all that apply)

□ Angioplasty
□ Appendectomy
□ Bowel resection
□ Cardiac Stents
□ Coronary Artery Bypass
□ C-Section
□ Defibrillator/Pacemaker Placement
□ Carpal Tunnel Release
□ Cataract
□ Gall Bladder surgery
□ Elbow Surgery
□ Gastric Bypass
□ Hernia Repair
□ Hip Replacement
□ Hysterectomy
□ Knee Replacement
□ Knee Arthroscopy
□ Mastectomy
□ Thyroidectomy
□ Shoulder Surgery
□ Other:_____
□ Other:_____
□ Other:_____
□ Other:_____

Current Medications:

_____
_____
_____

Allergies and Reactions:

_____
_____
_____

FEMALES ONLY:

Have you started your period? □ No □ Yes If yes, month/year_____
Have your periods ceased? □ No □ Yes If yes, month/year_____
Are you currently or possibly pregnant? □ No □ Yes

Family Medical History:						
Has anyone in your family had the following? Check any that apply, and the affected individual(s):						
□ Anesthesia Complications	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Bleeding Disorders	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Cancer	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	→Type_____
□ Depression	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Diabetes	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Heart Disease	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Hypertension	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Osteoarthritis	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Scoliosis	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Spine Disorders/Deformity	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Stroke	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	
□ Suicide	□ Mother	□ Father	□ Grandparents	□ Sister	□ Brother	

Social History:
Marital status: □ Single □ Married □ Divorced □ Widowed □ Other: _____

Highest level of education: □ Did not graduate HS □ High School graduate □ College Graduate □ Other_____

Employment Status:
□ Employed full-time □ Disabled □ Other: _____
□ Employed part-time □ Retired □ Other: _____
□ Unemployed □ Student □ Other: _____

Current or past Occupation: _____ If unemployed, last time you worked_____

Do you use tobacco or nicotine products? □ No □ Yes If yes, how much and what form: _____

Do you drink alcohol? □ No □ Yes If yes, how much and how often: _____

Do you exercise? □ No □ Yes If yes, how much how often: _____

Review of Systems: check all that apply in the last 3 months:

General:
□ Fever
□ Chills
□ Night sweats
□ Unintended weight loss
□ Fatigue

Eyes/Ears:
□ Double vision
□ Glasses/contacts
□ Ringing in ears
□ Hearing loss

Nose/Oral:
□ Sinus infection
□ Hoarseness
□ Difficulty swallowing

Gastrointestinal:
□ Changes in appetite
□ Heartburn
□ Constipation

Cardiac:
□ Chest pain
□ Racing heart beats
□ Skipping heart beats

Psychological:
□ Anxiety
□ Depressed mood
□ Mood swings

Respiratory:
□ Excessive snoring
□ Shortness of breath with little exertion
□ Exposure to someone with tuberculosis

Skin:
□ Rashes
□ Sores
□ Hairy patches
□ Changes in nails/hair
□ Easy bruising

Genitourinary:
□ Urine frequency
□Unable to empty bladder
□ Incontinence

Neurological:
□ Headaches
□ Confusion
□ Loss of balance
□ Numbness
□ Tingling

Musculoskeletal:
□ Joint pain
□ Stiffness
□ Swelling
□ Gout
□ Atrophy

Heme/Lymphatics:
□ Easy bleeding
□ Transfusion reactions
□ Persistent infections
□ Latex allergy

Expectations: What expectations do you have for your treatment at this office?
(CHECK ONLY ONE RESPONSE FOR EACH STATEMENT)

As a result of my treatment, I expect…	Not Likely	Slightly Likely	Somewhat Likely	Very Likely	Extremely Likely
a) Complete pain relief	□	□	□	□	□
b) Moderate pain relief	□	□	□	□	□
c) To be able to do more everyday household or yard activities	□	□	□	□	□
d) To be able to sleep more comfortably	□	□	□	□	□
e) To be able to go back to my usual job	□	□	□	□	□
f) To be able to do more sports, go biking, or go for long walks	□	□	□	□	□

FOR INTERNAL USE ONLY:

PROVIDER SIGNATURE: _____ **DATE:**_____

Pain Diagram

Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Tingling 0000
Pain XXXX
Numbness IIII